EDITOR'S CHOICE

Public Health Advocacy

This issue of the Journal focuses on public health advocacy. According to dictionary definitions, "to advocate" means to espouse a cause by argument, to plead in favor of, to recommend publicly. The business of improving population health has always been linked to action. Buried in seemingly dry public health statistics is the evidence of preventable illness and death. To document this is not enough. To effect change may never be politically "safe" and is never a simple matter.

The classic tale of cholera in mid–19th century London reminds us that at its finest, public health is data driven and intervention oriented. First document, then analyze, then act, then document the effect. During the 1848 cholera epidemic, John Snow mapped out the locations of cholera cases and demonstrated that the epidemic raging in London was not evenly distributed across the city (*Snow on Cholera: Being a Reprint of Two Papers*. New York, NY: Commonwealth Fund; 1936). This observation led to the identification of different water sources from commercial water suppliers, and eventually to the act of removing the handle from the Broad Street pump that was delivering contaminated water downstream of London from the Thames. Cholera cases declined in the surrounding area. The tale of the Broad Street pump must have been spread across London, as others—no longer Snow alone—began to advocate the provision of clean water.

The requirement for public health advocacy is even more apparent today, when it is what we eat, drink, and smoke, along with how we exercise and get health care, that to a great degree determines our health. Today's chronic disease burden—cardiovascular disease, cancer, and diabetes—is attributable not to bacteria but to an array of risk factors embedded in community life. People will eat, drink, and exercise in the ways available to them. In New York City, advocacy data are data showing that the prevalence of adult smoking is twice as high in impoverished East Harlem as in the adjacent—but affluent—Upper East Side.

The availability of surveillance data on risk factors as well as disease rates is a real contribution by government to the ability of communities to act as advocates for their health. For beyond these data lie stories of disadvantaged communities in which billboards advertise alcohol and cigarettes, parks are run down, and streets are violent. These factors, too, can be changed, as history shows. Anonymous telephone surveys and data tabulation alone will not help us here. "Engagement," "participation," and "community partnerships" are much-used—perhaps overused—terms. The challenge to improve public health calls for the involvement of everyone, including those outside the health sector. Learning how to engage more effectively with communities is essential for health professionals who wish to create programs and institute policies that measurably improve health and lives.

As important as data are to public debate, what people see, hear, and experience is often what drives passionate commitment to changing the public's health. The basis for advocacy is not limited to what we count and the statistics we derive. If successful health improvement were based only on these "facts," we would be freed from the enduring controversies that surround efforts to alter ways in which people eat, drink, and smoke. Public health is also personal—the family member or friend who died from a preventable cause, the human story that underlies the statistics we cite. Public health takes place in boardrooms, on street corners, in our homes, and in the legislature. So, too, does public health advocacy. ■

Mary T. Bassett, MD, MPH
Associate Editor
Deputy Commissioner, New York City Department of Health and Mental Hygiene